

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**=62-022051**  
STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. **042** Primary Registration District No. **1000** Registrar's No. **793**  
**FILED JUL 16 1962**

VS 300  
Rev. 4/59

15117

25117

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DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

C.A. Potter, M.D. MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <b>St. Joseph</b>		c. CITY OR TOWN <b>St. Joseph</b>	
Length of stay in 1b <b>21 years</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Missouri Methodist Hosp.</b>		d. STREET ADDRESS (If outside, give location) <b>2823 Faraon St.</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LESTER</b> Middle <b>B.</b> Last <b>MILLER</b>		4. DATE OF DEATH Month <b>July</b> Day <b>6</b> Year <b>1962</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7/9/1896</b>
9. AGE (last birthday) <b>65</b>		10. IF UNDER 1 YEAR Months <b>65</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Scout Executive</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Boy Scouts of Amer.</b>	
11. BIRTHPLACE (City and state or country) <b>Welda, Kansas</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Ed Miller</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Lily Hill</b>	
14. NAME OF HUSBAND OR WIFE <b>Mabel</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes W.W. #1</b>	
16. SOCIAL SECURITY NO. <b>[REDACTED]</b>		17. INFORMANT Address <b>Mrs. Mabel Miller, 2823 Faraon, St. Joseph, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c) <b>years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>few days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <b>4:03 a.</b> Month, Day, Year <b>June 27, 1962</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>St. Joseph</b>		COUNTY <b>Missouri</b> STATE <b>Mo.</b>
21. I attended the deceased from <b>June 27, 1962</b> to <b>July 6, 1962</b> and last saw him alive on <b>July 5, 1962</b> Death occurred at <b>1100x 4:03 a.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.		22. SIGNATURE (Degree or title) <b>C.A. Potter, M.D.</b>	
22b. ADDRESS <b>706 Francis St. Joseph, Mo.</b>		22c. DATE SIGNED <b>7-10-62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>7/9/1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>	
23d. LOCATION (City, town, or county) <b>St. Joseph, Missouri</b>		24. FUNERAL DIRECTOR <b>Heston - Bowman</b>	
ADDRESS <b>St. Joseph, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>July 11, 1962</b>	
26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Goodell</b>			

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

JUL 24 1962

JUL 17 1962

JUL 18 1962

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed William Spalding

Licensed Embalmer No. 4535

P. O. Address St Joseph 2nd

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.